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Trouble on the Exchanges — Does the United States Owe Billions to Health Insurers?

Nicholas Bagley, J.D.

Yet another bruising fight has erupted over health care reform. On September 9, 2016, the Obama administration offered to open settlement negotiations with health insurers that have sued the United States to recover billions of dollars that they claim they are owed. Congressional Republicans are incensed, believing that any settlement would illegally squander taxpayer dollars in a last-gasp effort to save the Affordable Care Act (ACA).

As with many disputes over health care reform, the partisan squabbling has elevated an obscure legal question to public attention. The unfortunate result, however, is that careful legal analysis can get lost in the din. Are insurers in fact entitled to the risk-corridor money that they believe they are owed? If so, does the administration have the legal authority to pay them? As it happens, the law offers reasonably clear answers to both questions.

When Congress enacted the ACA, it feared that insurers might be reluctant to participate in the health insurance exchanges. The markets were new and untested; actuarial models that worked well in the prior era of medical underwriting would be useless.

To coax insurers onto the exchanges, Congress created a temporary risk-corridor program. For 3 years — from 2014 through 2016 — the Department of Health and Human Services (HHS)

would cover some of the losses for insurers whose plans performed worse than they expected. Insurers that were especially profitable, for their part, would have to return to HHS some of the money they earned on the exchanges.

The risk-corridor program thus aimed to protect insurers from large losses. The concept was not novel; the program was modeled on a similar one in Medicare Part D, which also used risk corridors to encourage reluctant private insurers to participate in a newly formed insurance market. As with Part D, more participation would mean more competition, which would drive down premiums and make health insurance more affordable.

When insurers signed up to sell health plans on the exchanges, they did so with the expectation that the risk-corridor program would limit their downside losses. But there was an unanticipated hitch: the ACA did not appropriate any money to make risk-corridor payments. For 2014, HHS could rely on existing authority to make these payments out of the money it received from profitable health plans. But for 2015 and 2016, Congress tightened the screws. In omnibus appropriations bills covering both years, it refused to appropriate the money to fully fund the program. That meant that the risk-corridor program would have to be budget neutral: payments out could not exceed payments in.

That requirement proved to be bad news for health insurers. In late 2015, HHS announced that insurers were owed \$2.87 billion in risk-corridor money for 2014 — about \$400 per exchange enrollee. Payments into the program, however, amounted to just \$362 million. As a result, HHS could pay

insurers just 12.6% of what they were owed.

The inability to make full risk-corridor payments devastated some insurers. Hit particularly hard were the new cooperative health plans, which were established with the support of generous ACA loans. By the end of summer 2016, just 7 of 23 co-ops were still in business. As the co-ops collapsed, almost a million people were forced to look elsewhere for coverage.

The loss of the co-ops, together with the withdrawal of several large insurers from a number of states, has led to a sharp reduction in competition on the exchanges. The Kaiser Family Foundation has estimated that in 2017 only 62% of exchange customers will be able to choose from among three or more insurers, down from 85% the year before.¹ Nearly one in five customers will have just one choice. The lack of vibrant competition will compromise efforts to hold down costs: premium increases in 2017 are expected to be considerably larger than in previous years.

Health insurers struck back. In February 2016, a failed Oregon co-op filed a class-action lawsuit to recover what it was owed under the risk-corridor program. At least seven other lawsuits seeking reimbursement have since been filed. The insurers' claims are straightforward. In enacting the ACA, Congress promised to make risk-corridor payments to health plans that performed poorly on the exchanges. That financial promise created a legal entitlement. And that entitlement is enforceable in court.

For now, the Justice Department is fighting the lawsuits. But the insurers' legal arguments have considerable force. Indeed, HHS has openly acknowledged that

risk-corridor payments are “obligation[s] of the United States for which full payment is required.”² The administration may recognize that it is playing a losing hand — which is why, in September, it announced that it was “open to discussing resolution” of the risk-corridor claims.

House Republicans immediately cried foul. “The Administration’s explicit offer to settle these lawsuits,” wrote the chairman of the House Committee on Energy and Commerce, “appears to be a direct circumvention of clear congressional intent to prohibit the expenditure of federal dollars on this program.”³

Congressional Republicans believe that settling these cases would be unlawful for two reasons. First, they insist that they changed the terms of the risk-corridor deal when they passed appropriations statutes that made the program budget neutral. Insurers' entitlement to full risk-corridor payments ends, they argue, when funding for the program is exhausted.

On this question, the Republicans are mistaken. As the Government Accountability Office has explained, “the mere failure to appropriate sufficient funds is not enough” to change the scope of an entitlement.⁴ And that's all the appropriations statutes are: “mere failure[s] to appropriate sufficient funds.” They do not purport to change what health plans are entitled to. So the promise that the ACA made has not been undone.

Second, congressional Republicans maintain that the administration cannot settle the cases because Congress hasn't appropriated the money to pay court judgments. Without an appropriation, they argue, the United States can't make a payment even if a court orders that the money be

paid. In other words, Congress is always free to refuse to honor its debts — and it has refused to honor these particular debts.

The Republicans acknowledge that an existing, permanent appropriation known as the Judgment Fund normally allows the executive branch to settle lawsuits against the United States. By its terms, however, the Judgment Fund is available only when payment is “not otherwise provided for.” Drawing support from a memo compiled by the Congressional Research Service, they believe that they “otherwise provided for” risk-corridor payments when they partially funded the program.

But in fact the Judgment Fund is not unavailable whenever Congress chooses to partially fund a program. It is unavailable only when Congress has designated an alternative source of funds to pay money judgments arising from a failure to fulfill the United States’

financial obligations.⁵ Because Congress has made no such designation here, the Judgment Fund appears to be available to settle the risk-corridor lawsuits.

Health insurers thus appear to have a strong claim to several billion dollars from U.S. coffers. Which is not to say that insurers are sure to be paid. Under the next president, for example, Congress could amend the Judgment Fund to prohibit payment. And lawyers continue to wrangle over the complexities of appropriations law, creating some uncertainty about the litigation.

Eventually, however, Uncle Sam may have no choice but to pay up. With that upshot in mind, the Obama administration’s willingness to open settlement negotiations appears neither feckless nor unlawful. On the contrary, it is the responsible thing to do.

Disclosure forms provided by the author are available at NEJM.org.

From the University of Michigan Law School, Ann Arbor.

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